KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
NOTICE OF ACTION

PROGRAM: ☐ **Older Americans Act** ☐ **Senior Care Act**

Date of Notice:	
TO:	FROM: Agency:
Attention:	Phone:

Service	No. of Units (Specify Per Day or Week)	Self Dir. Y/N?	Provider Name	Dates of Service From	To	Provider Unit Cost
						$
						$
						$
						$
						$
						$

☐ Customer Service Worksheet Attached

Copay: %	Paid To:

Comments, Message, or Explanation of Action:
☐ Effective _____ , your services and/or plan of care are being implemented as identified above;
☐ Or other:

cc:
Regulatory Reference(s): KDADS FSM
You may contact your case manager at the phone number above.
Please carefully read the Customer Rights and Responsibilities with this NOA.

Case Manager Signature: _____ Date: _____